Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
14th May 2019

Prescribing Points and the Traffic light system are available on the OCCG website. The OCCG Formulary is available online. -links below.
This document summarises the discussions and decisions taken at APCO in May 2019.

Local Guidance: OCCG Formulary

The classifications are:

- Red – Specialist Prescribing Only
- Amber Continuation - Medicines which should be initiated or recommended by a specialist for continuation in primary care. The specialist must notify the GP that the prescribing responsibility has been transferred.
- Amber Shared Care Protocol - Medicines which are appropriate to be initiated and stabilised by a specialist, once stabilised the medicine may be appropriate for responsibility to be transferred from secondary to primary care with the agreement of a GP and a formal 'shared care' agreement. The shared care protocol must be approved by the Area Prescribing Committee Oxfordshire (APCO).
- Green - Medicines which are suitable for initiation and ongoing prescribing within primary care.
- Brown – Prescribe only in restricted circumstances
- Black – Not recommended for use in primary or secondary care
- Holding List – Pending APCO / Priorities Forum decision

Drug	Traffic Light Classification	Rationale
Benralizumab for treating severe eosinophilic asthma	Red	In line with NICE TA565 (NHS E commissioned)
Certolizumab pegol for treating moderate to severe plaque psoriasis	Red	In line with NICE TA574
Tildrakizumab for treating moderate to severe plaque psoriasis	Red	In line with NICE TA575
Dupilumab for treating moderate to severe atopic dermatitis	Red	In line with NICE TA 534
Tisagenlecleucel for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic therapies	Red	In line with NICE TA567 (NHS E commissioned)
Pertuzumab for adjuvant treatment of HER2-positive early stage breast cancer	Red	In line with NICE TA 569 (NHS E commissioned)
Brigatinib for treating ALK-positive advanced non-small-cell lung cancer after crizotinib	Red	In line with NICE TA 571 (NHS E commissioned)
Daratumumab with bortezomib and dexamethasone for previously treated multiple myeloma	Red	In line with NICE TA573 (NHS E commissioned)
Ocrelizumab for treating relapsing–remitting multiple sclerosis	Red	In line with NICE TA 533 (NHS E commissioned)

Drug	Traffic Light Classification	Rationale
Ertugliflozin as monotherapy or with metformin for treating type 2 diabetes	Brown	In line with NICE TA 572. Second SGLT2i option, to review the formulary position when cardiovascular outcome data is available
Abatacept for treating psoriatic arthritis after DMARDs (terminated appraisal)	Black	In line with NICE TA 568
Pembrolizumab for treating recurrent or metastatic squamous cell carcinoma of the head and neck after platinum-based chemotherapy (terminated appraisal)	Black	In line with NICE TA 570
Bosutinib for untreated chronic myeloid leukaemia (terminated appraisal)	Black	In line with NICE TA 576
Aerochamber Plus Flow-Vu spacer	Brown	Includes a visual tool that helps count breathes, assure correct use and delivery. For use in patients with carers (including children)
Nebivolol for Heart Failure	Brown	3rd line beta blocker option after bisoprolol and carvedilol
Dapagliflozin for type 2 diabetes	Green	1st line SGLT2i option for type 2 diabetes (empagliflozin also first line) Dapagliflozin has shown CV outcome benefit in primary prevention; empagliflozin, in secondary prevention
Pramipexole for restless leg syndrome	Green	Previously shared care, but only dopamine agonist with a SCP. No ongoing monitoring required after first three months. GPs already initiating so no need for shared care.
Pigmanorm cream	Black	Not recommended in line with Policy No 6i (TVPC16) Aesthetic treatments for adults and children
Riboflavin	Red	For mitochondrial disorder. Consultant use only. Approved at MMTC
Caplacizumab	Red	For acquired thrombotic thrombocytopenic purpura, via patient access scheme. Approved at MMTC
Desferasirox	Red	Approved at MMTC as 2nd line in MDS. In line with TVPC policy on Iron Chelating Drugs in MDS
Dexmedetomidine	Red	For sedation of mechanically ventilated adult patients in critical care. Approved at MMTC

Miscellaneous

Local Oxfordshire update and amendment to Policy 266 Sequential use of a third or subsequent biologic therapy for psoriasis

Policy 266b (TVPC44) Sequential use of a third or subsequent biologic therapy for psoriasis last received a full update in 2016. TVPC Priorities Committee has agreed minor updates to the policy (new NICE TAs added and additional wording on biosimilars). Oxfordshire, after discussion with the local clinicians are proposing a further set of changes which will take OCCG and OUH outside the TV wide policy.
The relevant changes are;

1. not to count a switch at first line from a biosimilar back to the originator drug as a second biologic – this is a universal statement across all biologic drugs
2. not to count a switch of a first-line drug to a second drug as a second biologic when the ONLY problem is a documented injection site reaction – this is to accommodate a small number of patients who have issues with components such as citrate so not to disadvantage them.
3. Explicit allowing of dose escalation in adalimumab in line with BAD guidance – this has been approved via MMTC already and is in line with licensed dosage.
4. The permitted use of a fourth-line biologic in line with an agreed local pathway ONLY when the switch is to an agent with a mode of action targeting IL-17a or IL-23 which has NOT been used before. TVPC allow 3 in line with NICE

Discussion on point 4 – This has not been considered by TVPC or NICE as there is no evidence past use of two biologics, and it is unlikely that there will be. However, there are now drugs available with different modes of action.
It was confirmed it would likely be cost neutral and because newer biologics are more competitively priced you may find that there are some cost savings. The alternative to not using a 4th biologic is prolonged hospital admissions which will be costly. Once a patient is started on a biologic unlikely to be able to stop, so allowing a change to a 4th line is more cost effective.
This policy will apply just to Oxfordshire patients at the moment –there is a potential it will be considered Thames Valley wide. It was confirmed patients seen from other areas will need to go through appropriate pathway like IFR. The dept. will need to be more pragmatic as they go through pathway to take in to account the different modes of action, so a pathway has been designed to ensure that sensible and consistent choices are made. It was asked if we risk setting a precedent with the lack of evidence, and confirmed these changes in sequential use of biologics are inevitable.
The process dermatology follow around communication to patients and primary care was queried. Stated that they will have multiple discussions with the patient and the choice of medication will be guided by the clinic. Main communication with primary care is in the clinic letters. The GPs confirmed it would be useful for dermatology to produce a leaflet for GPs advising them what to do if a patient is on a biologic e.g. read code immunosuppressed, not vaccines needed. Add as a hospital only drug to EMIS.

Shared Care Protocols (SCP)

Methotrexate for use in ocular inflammation (ophthalmology) – adults and paediatrics shared care protocol

Medicines Optimisation Team
APCO Bullet Points May 2019
Recommendations ratified at OCCG Clinical Ratification Group (June 2019)

Mycophenolate mofetil for use in ocular inflammation (ophthalmology) – adults and paediatrics shared care protocol
Oral tacrolimus capsules (Adoport) for use in ocular inflammation (ophthalmology) – shared care protocol

Three updates to ophthalmology protocols were presented. There is a separate shared care protocol for ophthalmology use only and it is on new template. Minor updates to all sections as noted on the front sheet, in line with BSR guidelines and handbook. Ongoing monitoring schedule amended as per updated BSR DMARDs guidelines. BSR guidelines recommend blood tests two weekly for the first 6 weeks of treatment however local decision has been made to reduce to 2 weeks after initiation then monthly. This only results in one less blood test.

Whilst OUH maintains responsibility for the supply of the first month of treatment it is requested that patients are able to have the initial blood test at their local GP practice. It is highlighted to the patients that it is their responsibility to book this test, and part of them consenting to treatment. The specialist pharmacist in the uveitis service will check these results via EPR and liaise with the GP if there are any concerns.

It was asked if GPs would have any issues with this, is there a risk the blood results may be missed and who takes responsibility? If the GP has made the request they are responsible, but the GP would require the results ready to prescribe at 1 month anyway. It was confirmed the patient would have a follow up phone call with the clinic, so they would chase at that point if they haven't been for the test. It was confirmed for out of area patients they can't see the results on EPR so the pharmacist phones the GP. Other areas use a system called DAWN which allows sharing of results and flags up out of range results. This will be looked in to this as an option going forward.
It was asked for the paediatric dosage of folic acid to be clarified and for the immunisation sentence to be clarified highlighting that Fluenz must not be given to adults.
The removal of eGFR monitoring was questioned and it was confirmed this is routinely included in U&Es so not stated specifically.

All Approved subject to changes noted above

Guidelines

Blood Glucose Monitoring Guidelines

This guideline has been adopted from Nene CCG. The guidance incorporates and replaces our current guidance Self-Monitoring of Blood Glucose in Type 2 Diabetes. The significant change is that the first line recommendation is now for meters with test strips costing less than £6 for 50 (currently <£10 for 50). The Finetest Lite meter is the example given in the guidance as there is experience with this meter and is consistent with other local areas. The only other meter currently available with strips <£6 for 50 is the GlucoRx Q, which would also be an option if preferred by practices. It is expected that more meters will fall in to this bracket in the future.

In 2018, OCCG spent £1.6 million on blood glucose test strips. If all patients in Oxfordshire were to switch to Finetest Lite (or equivalent), this would save between £640,000 - £960,000 per year. However, whilst the Finetest Lite meter would be suitable for most patients, there are cohorts who require meters with extra functions. The guidance defines these cohorts and suggests appropriate meters to consider. Also, switching is not recommended unless part of a review of blood glucose monitoring. It is recommended to start all appropriate patients who require a new meter on Finetest Lite (or equivalent).

To compliment the guidance, the Choosing a Blood Glucose Monitor table has been updated to reflect the new meters discussed. The meters have been aligned to those in the new guideline, and some of the supporting information has been removed as it is now covered in the updated guideline.

The question was raised as to whether this was about actively switching patients. It was confirmed this guidance is about new patients, but could be used as part of the Prescribing Incentive Scheme as a cost saving switch. Concerns were raised around switching impacting on nurse time and not benefiting the patient. Also, concerns that patients often don't trust their new meter and end up testing with two devices. Any switches would need to follow the guidance and should be done as part of a review of purpose of blood glucose monitoring and interpretation of results. It was suggested this could be done in a group setting and that we need to work with secondary care as they are often the ones who initiate.

Approved

Botulinum Toxin A - Update

OCCG currently have a TVPC policy with local amendments. APCO agreed to do these local amendments subject to OUH producing audit evidence in 12 months' time. It is now coming up for review but there is no audit data available. It suggested 3 ways forward:

- Agree to continue with the amended policy without audit data OR
- Agree to continue for 6 months only during which time audit data must be received but notice to be served on the OUHFT that the local policy changes will be withdrawn at the end of that time if audit data has not been received OR
- Withdraw amendments to the policy i.e. withdraw local treatment at once

Following discussion the second of these is recommended. In the absence of evidence for the locally agreed options, the audit outcomes need to show a percentage of response to treatment. RMOC are reviewing the use in a range of unlicensed variations, although probably not going to be reviewed. It was suggested this is brought back to the January APCO, so the specialties should audit patients June-November. The local variations are:
Sialorrhoea
Achalasia
Anismus
Spasmodic Dysphonia

Ophthalmic Focal Dystonia

Approved Option 2

Changes to Policy 285 (TVPC73) Flash Glucose Monitoring System (Freestyle Libre) in line with NHSE

The updated TVPC policy was presented which has been changed to reflect the NHSE criteria. There are a number of differences between OCCG's current and the proposed policy. The accompanying documentation has comments on the current policy detailing where the new policy will be different. The intention of both polices is the same. It was suggested APCO make a local amendment, effectively merging our current policy with the updated TVPC/NHSE criteria. The two areas that would be added to the local policy are:

- Those who meet the current NICE criteria for insulin pump therapy (HbA1c ≥ 69mmol/mol (8.5%)) or disabling hypoglycaemia (as described in NICE TA151) where a successful trial of FGS may avoid the need for pump therapy.
- Frequent admissions (>2 per year) with either diabetic ketoacidosis (DKA) or hypoglycaemia

APCO felt DKA admissions were an important group to include, however the risk of patients purposefully having a DKA to be eligible for a FGS was raised.

This new technology is exciting and has been welcomed by patients and professionals. However the financial implications could be high. There should be a reduction in spend on traditional blood glucose testing and potentially reduced admissions. It was raised that NHSE will only reimburse against their criteria, if we make changes to the policy this may impact reimbursement.

Approved

Chair's Actions

SGLT2 inhibitor checklist, letter to prescribers and letter to patients have been updated to include ertugliflozin and additional safety information. The safety information includes:

- What to do when unwell
- Fournier's gangrene
- Amputation risk